MDR Tracking Number: M4-02-4739-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for CPT codes 63090, 93091, 22585, 63090-85, and 93091-85.

   b. The request was received on March 15, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA's
   c. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. HCFA's
   c. Audit summaries/EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on April 12, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on April 12, 2002. The response from the insurance carrier was received in the Division on April 29, 2002. Based on 133.307 (i) the insurance carrier's response is untimely; therefore, the Commission shall issue a decision based on the request.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated April 10, 2002 that… "…The carrier contends that the operative report supports the excision of the vertebral and plate rather than a corpectomy. However, the operative report does state, 'We evacuated the disk in this manner and then used the curves to clean off the cartilage on the endplates and the osteotomes to remove the adjacent portion of the vertebral bodies.' During this procedure, the end plate is not simply perforated, but the surgeon actually removed the adjacent portion of the vertebral body, and hence, the applicable code has been billed correctly. In order for the intravertebral prosthesis to fit and be inserted correctly, this procedure is necessary… Since a hemicorpectomy, 63090, is documented and was performed, it is not included in the arthrodesis code, 22558…The carrier is also denying code 22585 stating we should have billed this code with the appropriate modifer according to page 60 of the Texas Workers' Compensation Commission Fee Guidelines. The modifier '65' was submitted originally with the appropriate code 22558. Code 22585 is anterior arthrodesis, 1st level the additional level code for the anterior arthrodesis (2 level were performed). The Texas Workers' Compensation Medical Fee Guidelines states on page 65; 'When another surgeon performs the antieror 'APPROACH' BOTH SURGEONS SHOULD BILL THE ARTHRODESIS CODE WITH MODIFIER 65.' This was done for the primary anterior arthrodesis code. However, since the vascular surgeon only made the anterior incision (APPROACH), it is not necessary to append the modifier 65 on the additional level anterior arthrodesis code, 22585. There was not a co-surgeon present for the additional level fusion performed, only physician assistant assisting in the primary procedure… The carrier has failed to note that a 'MINIMAL DISKECTOMY' is included in arthrodesis. Please note Surgeon…. And Assistant Surgeon… did a **total diskectomy** in which the TWCC Advisory of 97-01 page 3 states; 'A full diskectomy procedure may be billed separately if not included as part of the global procedure for arthrodesis.' 63090 hemicorpectomy is the primary procedure and should be reimbursed at 100% this rule was quoted because it applied in this situation. 63090 was the primary procedure and 22558, fusion was the secondary procedure. Therefore the multiple procedure rule applies to 22558. The carrier states that AAOS recognize that removal of a disc is not always necessary or integral to the performance of a fusion… Finally, the carrier is denying procedure code 22899-85 for the Assistant Surgeon as not being document. This denial does not make any sense. If you review the Operative Report it states the insertion of spinal prosthesis/implant. Its funny how the carrier denies the Assistant Surgeon as not being documented and the Surgeon's procedure code 22899 was paid and was documented. The carrier is looking at the same operative report…"

2. Respondent: Response submitted untimely.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is July 2, 2001.

2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
07/02/01	63090	$5,100.00	$0.00	N	$4,248.00	MFG, SGR (I)(D)(1)(a) Advisory 97-01	Operative report supports services were rendered as billed. Reimbursement in the amount of $4,248.00 is recommended.
07/02/01	63091	$1,200.00	$0.00	N	$708.00	MFG, SGR (I)(D)(2)	Operative report supports services were rendered as billed. Reimbursement in the amount of $708.00 is recommended.
07/02/01	22585	$888.00	$0.00	F	$637.00	MFG, SGR (I)(E)(1)	Operative report supports services were rendered as billed. Reimbursement in the amount of $637.00 is recommended.
07/02/01	63090-85	$2,550.00	$0.00	N	$424.80 Per the modifier description the modifier "-85" reimbursement is 10% of the MAR$	MFG, SGR (I)(4)(A) Modifier General Instruction	Operative report documents that assistant was present and services were rendered as billed. Reimbursement in the amount of $424.80 is recommended.
07/02/01	63091-85	$600.00	$0.00	N	$120.00 Per the modifier description the modifier "-85" reimbursement is 10% of the MAR$	MFG, SGR (I)(4)(A) Modifier General Instruction	Operative report documents that assistant was present and services were rendered as billed. Reimbursement in the amount of $120.00 is recommended.
Totals		$10,338.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$6,137.80.**

The above Findings and Decision are hereby issued this 28th day of February, 2003.

Medical Dispute Resolution Officer
Medical Review Division

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $6,137.80 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 28th day of February, 2003.

Medical Dispute Resolution
Medical Review Division